STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155796	A. BUILDING 00 B. WING	09/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDARS THE	14409 SUNRISE CT LEO, IN 46765

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: September 5, 6, 7, and 8, 2023 Facility number: 001215 Provider number: 155796 AIM number: 100450890 Census Bed Type: SNF/NF: 33 Residential: 7 Total: 40 Census Payor Type: Medicare: 5 Medicaid: 13 Private: 22 Total: 40 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed September 12, 2023	F 0000	=”” span=””> =”” span=””> =”” span=””> We respectfully request consideration for paper compliance. If you have any questions or concerns, please contact Amanda Duggan, HFA at 260-627-2191. Thank you and have a great day! Amanda Duggan, HFA	
F 0583 SS=D Bldg. 00	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amanda Duggan	Health Facility Administrator	09/28/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.			
	Based on observation, interview, and record review the facility failed to ensure privacy was maintained for 1 of 6 residents reviewed (Resident 23). Findings include: During an observation on 9/5/23 at 7:54 AM an Indiana Physician's Orders for Scope of Treatment (POST) form was observed taped to the wall above the head of Resident 23's bed. The form contained Resident 23's name, date of birth, a	F 0583	All residents have the right to personal privacy and confidentiality of his or her personal medical record. This requirement was not met by one of the six residents that were reviewed. All residents have potential to be affected by this requirement not being met. All residents will be reviewed for personal privacy and confidentiality of his or her	09/28/2023

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	medical record number and orders pertaining to cardiopulmonary resuscitation, medical interventions, antibiotics, and artificially administered nutrition. Resident 23's record was reviewed on 9/6/23 at 11:38 AM. Diagnoses included nontraumatic intracerebral hemorrhage in hemisphere, cortical, expressive language disorder, idiopathic normal pressure hydrocephalus. A review of Resident 23's current annual Minimum Data Set (MDS) dated 8/2/23 indicated his Basic Interview for Mental Status (BIMS) score was 2 (severely cognitively impaired) and unable to be interviewed. During an interview on 9/6/23 at 11:35 AM, Resident 23's sister who was his Power of Attorney indicated she did not know what the form was or why it was posted in the room. In an interview on 9/6/23 at 11:47 AM, The Social Services Director indicated a prior member of management, no longer employed by the facility had directed staff to hang the POST form above Resident 23's bed. A current policy titled HIPPA Privacy Compliance Summary, undated, provided by the Administer on 9/6/23 at 1:40 PM indicated private health information should be protected and only accessed by authorized personnel. 3.1-3(o)		personal medical record. Staff will be educated on the residents' right to privacy and confidentiality of his or her personal medical record. (Attachment A) Audits will be completed daily for two weeks, weekly for eight weeks and then monthly until 100% compliance is met for 6 months. Results will be reviewed daily and then monthly with the QAPI meetings. (Attachment B)	
F 0622 SS=D Bldg. 00	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements-			

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	(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.			

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	§483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary,			

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	consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. Based on record review and interview the facility failed to provide the resident with a written explanation of the Notice of Transfer or Discharge and Bed Hold Policy within 24 hours of a hospital transfer for 1 of 2 residents reviewed for hospitalization. (Resident 25). Findings include: Resident 25's record was reviewed on 9/05/23 at 9:04 AM. Diagnoses included hypo-osmolality, hyponatremia, type 2 diabetes mellitus, and hypertension. A review of Resident 25's current quarterly Minimum Data Set (MDS) dated 6/26/23 assessment indicated her Basic Interview for Mental Status (BIMS) assessment score was 13 (cognitively intact). A review of Resident 25's census record indicated she was hospitalized 5/16/23 to 5/20/23. A progress note, dated 5/16/23 at 7:51 PM, indicated Resident 25 had a witnessed fall and was being transported to the hospital. A progress note dated 5/20/23 at 111:27 AM indicated Resident 25 returned to the facility. A review of Resident 25's chart lacked documentation to show a Notice of Transfer or Discharge and Bed Hold Policy Notice was initialed and supplied to the family or resident's representative within 24 hours of discharge of her 5/16/23 hospitalization.	F 0622	All residents have the right to have a written explanation of the Notice of Transfer or Discharge and Bed Hold Policy within 24 hours of a hospital transfer. This requirement was not met by one of two residents reviewed. All residents have the potential to be affected by this requirement not being met. All transfers out will be reviewed within 24 hours of transfer out. During review staff will make sure that the Notice of Transfer or Discharge and Bed Hold Policy was sent with resident or mailed to POA/Guardian. Nurses will be educated on the requirement of the Notice of Transfer or Discharge and Bed Hold Policy being sent with each transfer out of facility. (Attachment C) Audits will be completed daily for two weeks, weekly for eight weeks and then monthly until 100% compliance is met for 6 months. Results will be reviewed daily and then monthly with the QAPI meetings. (Attachment B)	09/28/2023

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	A review of Resident 25's census record indicated she was hospitalized 6/15/23 to 6/19/23. . A progress note, dated 6/15/23 at 7:51 PM, indicated Resident 25 was being sent to the hospital due to low sodium. A progress note dated 6/19/23 at 7:18 PM indicated Resident 25 returned to the facility. A review of Resident 25's chart lacked documentation to show a Notice of Transfer or Discharge and Bed Hold Policy Notice was initialed and supplied to the family or resident's representative within 24 hours of discharge of her 6/15/23 hospitalization. In an Interview on 9/07/23 at 1:23 PM, the Administrator indicated the facility failed to provide Resident 25 or her representative with a written explanation of the Notice of Transfer or Discharge and Bed Hold Policy within 24 hours of her 6/15/23 and 5/16/23 hospitalization transfers. A current policy titled "Bed Hold Policy", undated, provided by the Administrator on 9/8/23 at 11:40 AM did not refer to providing the resident or her representative with a written explanation of the Notice of Transfer or Discharge and Bed Hold Policy within 24 hours of hospital transfer. No further policies were provided by time of survey exit. 3.1-12(a)(25)(26)			
F 0660 SS=D Bldg. 00	483.21(c)(1)(i)-(ix) Discharge Planning Process §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals,			

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	the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's			

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	comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. Based on interview and record review, the facility failed to ensure the provision of a discharge summary for 1 of 7 residents reviewed. (Resident 30). Findings include:	F 0660	All residents have the right to an effective discharge planning process that effectively transitions them to a post-discharge care and the reduction of factors leading to preventable readmissions. This	09/28/2023

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	Resident 30's record was reviewed on 9/7/23 at 10:00 AM. Diagnoses included partial left foot amputation, osteomyelitis (infection in the bone) of the left ankle and foot, diabetes, irregular heartbeat, heart failure and peripheral vascular disease. A review of Resident 30's current discharge Minimum Data Set (MDS) dated 7/7/23 indicated their Basic Interview for Mental Status (BIMS) score was 15 (cognitively intact). The MDS indicated the resident had a surgical wound and had been prescribed blood thinners. A review of a physician order dated 7/7/23 indicated the resident required wound care to the left foot weekly and PRN for soiling and/or dislodgement. A review of a physician order dated 6/24/23 indicated the resident had been prescribed Plavix (blood thinner). A review of a physician order dated 6/23/23 indicated the resident was to be monitored for adverse effects of blood thinners such as bruising and excessive bleeding. A review of a social service progress note dated 7/5/23 at 3:17 PM indicated Resident 30's discharge papers had been started. A review of a social service progress note dated 7/7/23 at 8:28 AM indicated Resident 30 was to be discharged to home with home health for wound care, physical therapy (PT) and occupational therapy (OT). The note indicated PT had informed the Director of Nursing of Resident 30's discharge plan.		requirement was not met by one of seven residents reviewed. All residents who discharge have the potential to be affected by this requirement not being met. All residents that discharge will have IDT review and way in on discharge goals and recommendations during Care Plans as well as education upon leaving. The IDT will be educated on the requirements of an effective discharge planning process. (Attachment D) Audits will be completed daily for two weeks, weekly for eight weeks and then monthly until 100% compliance is met for 6 months. Results will be reviewed daily and then monthly with the QAPI meetings. (Attachment B)	

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	A review of a discharge instruction sheet dated 7/5/23 indicated the social service director had completed a discharge summary. The discharge instruction sheet sections for medications and the nursing discharge summary were blank. In an interview on 9/8/23 at 10:53 AM, the Administrator indicated the nursing department should have provided the resident with discharge instructions for wound care and medications. A current undated policy provided by the Administrator indicated discharge planning concerns would be identified by all disciplines. 3.1-36(a) 3.1-36(a)(1) 3.1-36(a)(2)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on interview and record review the facility failed to ensure the provision of scheduled showers at resident preferance for 1 of 7 residents reviewed. (Resident 10). Findings include: During an interview on 6/6/23 at 9:45 AM Resident 10 indicated they had not been provided with routine showers as scheduled. Resident 10 indicated they signed each shower sheet upon completion of each shower. Resident 10 indicated they signed each shower sheet due to past	F 0677	All Residents have the right to maintain good nutrition, grooming, personal and oral hygiene. This requirement was not met by one of seven residents reviewed. All dependent residents have the potential to be affected by this requirement not being met. All dependent residents will have their shower schedule reviewed and updated. Nursing staff will be educated on resident rights, the shower schedule, the shower form	09/28/2023

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	episodes of the staff lying about skipping the resident's showers and then marking they had refused showers. Resident 10's record was reviewed on 9/6/23 at 10:05 AM. Diagnoses included multiple sclerosis and generalized muscle weakness. Resident 10's current comprehensive Minimum Data Set (MDS) dated 6/15/23 indicated their Basic Interview for Mental Status (BIMS) score was 15 (cognitively intact). The MDS indicated the resident was totally dependent on the staff for bathing. Resident 10's current care plan indicated the resident had a problem of a self-care deficit due to muscular dystrophy and the inability to bear weight with a goal date of 12/14/23. Interventions included extensive assistance by 2 staff members with showers each Monday and Friday and whirlpools each Wednesday and Saturday. Progress notes dated 7/16/23 at 6:19 PM indicated Resident 10 was to have a shower every Sunday and Thursday evening at 9:00 PM. Resident 10 was to sign a shower sheet when the shower was completed or if the shower was refused. The progress note indicated the resident had refused their shower and signed and dated the shower sheet. Progress notes dated 8/6/23 at 8:54 PM indicated Resident 10 was to have a shower every Sunday and Thursday evening at 9:00 PM. Resident 10 was to sign a shower sheet when the shower was completed or if the shower was refused. The progress note indicated the resident had refused their shower.		as well as resident's 10 need to sign the shower form with each scheduled shower. (Attachment E) Audits will be completed daily for two weeks, weekly for eight weeks and then monthly until 100% compliance is met for 6 months. Results will be reviewed daily and then monthly with the QAPI meetings. (Attachment B)	

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	Progress notes dated 9/3/23 at 8:10 PM indicated Resident 10 was to have a shower every Sunday and Thursday evening at 9:00 PM. Resident 10 was to sign a shower sheet when the shower was completed or if the shower was refused. The progress note indicated the resident had refused their shower. Resident 10's shower review sheets dated July 2023 indicated the resident had signed shower sheets on 7/2/23, 7/6/23, 7/20/23 and 7/30/23. Shower review sheets dated 7/23/23 and 7/27/23 did not portray Resident 10's signature. Resident 10's shower review sheets dated August 2023 indicated the resident had signed shower sheets on 8/6/23, 8/13/23, and 8/27/23. Shower review sheets dated 8/3/23, 8/17/23, 8/24/23 and 8/31/23 did not portray Resident 10's signature. Resident 10's shower review sheet dated 9/3/23 indicated the resident had signed the shower sheet. Resident 10's task sheet indicated the resident was to have a shower every Tuesday, Thursday and Saturday at 5:00 AM. The task sheet indicated the resident was totally dependent with showers on 8/9/23, 8/11/23, 8/25/23 and 9/1/23. The task sheet indicated the resident was independent with a shower on 9/3/23. The task sheet indicated showers were not applicable on 8/13/23, 8/16/23, 8/18/23, 8/20/23, 8/23/23, 8/27/23 and 9/6/23. In an interview on 9/7/23 at 1:18 PM, the Administrator indicated they were unaware of Resident 10's report of not receiving scheduled showers. The Administrator indicated residents were to receive all scheduled showers and			

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CEDARS THE	14409 SUNRISE CT LEO, IN 46765

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	refusals of showers should be reported to the nurse and documented. A current undated policy provided by the Administrator indicated residents would receive all scheduled showers. The policy indicated the nurse would be notified if a resident refused their shower. 3.1-38(a)(3)			
F 0727 SS=E Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on record review and interview, the facility failed to ensure a Registered Nurse (RN) worked 8 consecutive hours in the facility 11 days of 60 reviewed. Finding includes: On 9/6/23 at 11:24 AM staff schedules for the nursing department were reviewed from 8/1/23 to 9/1/23.	F 0727	The facility is required to have 8 hrs minimum of continuous RN coverage a day, seven days a week. This regulation was not met for 11 of 60 days. All residents have the potential to be affected by this deficient regulation. RN coverage will be reviewed daily. Director of Nursing and Infection Preventionist will be re-educated on this regulation. Audits will be	09/28/2023

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	The staffing schedule for 8/6/23 indicated 2 agency License Practical Nurses (LPN) worked during the 24 hours. No Registered Nurse (RN) worked on 8/6/23 for 8 consecutive hours. The staffing schedule for 8/13/23 indicated 2 agency LPNs worked during the 24 hours. No RN worked on 8/13/23 for 8 consecutive hours. The staffing schedule for 8/20/23 indicated 2 agency LPNs worked during the 24 hours. A RN worked on 8/13/23 for 1.25 hours, not for 8 consecutive hours. The staffing schedule for 8/27/23 indicated 2 agency LPNs worked during the 24 hours. No RN worked on 8/27/23 for 8 consecutive hours. A review of the facility's Payroll Based Journal Report dated 1/1/23 -3/31/23, indicated the facility failed to have an RN working 8 consecutive hours per day during the fiscal quarter on the following days: 2/4/23, 2/07/23, 2/11/23 2/17/23, 2/26/23, 2/27/23 and 2/28/23. In an interview on 9/7/23 at 11:45 AM, the Administrator indicated the facility failed to have a RN on staff every Sunday in August for 8 hours and there should have been. The facility did not have a policy regarding RN staffing hour requirements. No policy was provided by the survey exit. 3.1-17(b)(3)		completed daily for two weeks, weekly for eight weeks and then monthly until 100% compliance is met for 6 months. Results will be reviewed daily and then monthly with the QAPI meetings. (Attachment B)	
F 0756 SS=D Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each			

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	resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.			

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	Based on interview and record review the facility failed to ensure pharmacy recommendations were addressed timely for 1 of 5 residents reviewed. (Resident 12). Findings include: Resident 12's record was reviewed on 9/26/23 at 9:29 AM. Diagnoses included generalized anxiety disorder, unspecified dementia, moderate without behavioral disturbance, psychotic mood disturbance and anxiety, and heart failure, unspecified. Resident 12's current annual, Minimum Data Set (MDS) dated 8/31/23 indicated her Basic Interview for Mental Status (BIMS) score was 3 (severely cognitively impaired). The MDS indicated Resident 3 received antianxiety medication daily. Resident 12's current Care plan titled Uses Psychotropic Medication indicated the Resident 12 had a problem of risk of adverse effects, with a goal date of 11/30/23. Interventions included pharmacy consultations. Pharmacy Consultation Report dated 6/19/23 provided by the Administrator on 9/7/23 at 3:20 PM indicated a new order to increase Buspar to 5 mg three times daily from 5 mg twice daily had been written on 5/15/23 and had not yet been initiated. A Medical Visit Note dated 5/15/23 indicated the order for Buspar 5 mg twice daily should be discontinued and an order for Buspar 5 mg three times daily should be initiated. Physician orders dated 2/5/23 indicated Buspar 5 mg was ordered to be given twice daily. This	F 0756	All residents have the right to have their Pharmacy recommendations reviewed timely. This requirement was not met for one of five residents reviewed. All residents have the potential to be affected by this deficient practice. Pharmacy recommendations will be reviewed with in 24 hours of the recommendation being written and signed by the doctor within 72 hours. Nursing staff will be educated on the requirements of Pharmacy recommendations and the Pharmacy recommendation audit. Audits will be completed daily for two weeks, weekly for eight weeks and then monthly until 100% compliance is met for 6 months. Results will be reviewed daily and then monthly with the QAPI meetings. (Attachment B)	09/28/2023

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	order was discontinued 7/18/23. Physician orders dated 7/18/23 indicated Buspar 5 mg was ordered to be given three times daily. In an interview on 9/8/23 at 10:10 AM, Registered Nurse 4 indicated pharmacy recommendations are normally given to the physician or nurse practitioner the next business day and carried out within a few days. He was not sure why the order to change the frequency of Buspar had not been carried out in a timely manner. RN 4 indicated the order should have been carried out within a few days of receiving the pharmacy recommendation. During an interview on 9/08/23 12:25 PM, the Administrator indicated she did not have a policy pertaining to responding to pharmacy recommendations or receiving and transcribing physician's orders. 3.1-25(i)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling			

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	practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review the facility failed to ensure kitchen sanitation was maintained. 33 of 33 residents currently residing in the facility consumed food prepared in the facility kitchen. Findings include: During an observation on 9/5/23 at 6:00 AM a container of buttermilk was observed in the walk-in cooler. The container was about half full and a thick white substance was observed on top of the liquid that was a yellowish white. The date stamped on the container was 8/15/23. A container labeled lemon pudding indicated the expiration date was 9/3/23. A container labeled cherry pie filling indicated the expiration date was 8/22/23. A container labeled marshmallow sauce indicated the expiration date was 9/1/23. A container labeled western dressing was dated 7/13/23- 7/19/23. A container labeled ranch dressing did not have a date. A container stored with the other dressing bottles containing a white liquid did not have a label or date. An open package of salami was dated 8/16/23. 5 containers of salad were dated 9/1/23. In an interview on 9/5/23 at 6:22 AM, Cook 2 indicated leftover items should not be stored for more than 3 days. She indicated items should be used or discarded by the expiration date.	F 0812	All residents have the right to have their food prepared and maintained with proper kitchen sanitation. This requirement was not met for 33 of 33 residents. All residents have the potential to be affected by this deficient practice. Dietary staff will be reeducated on label and dating items, food storage, equipment cleaning procedures, and logging refrigerator and freezer temperatures each shift. Administrator and or Designee will sign off on the daily kitchen audits for 30 days and then there after monthly. (Attachment G) Audits will be completed daily for two weeks, weekly for eight weeks and then monthly until 100% compliance is met for 6 months. Results will be reviewed daily and then monthly with the QAPI meetings. (Attachment B)	09/28/2023

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	A shelf underneath a counter in the kitchen area were 9 skillets. The shelf contained multiple brown and tan specks, too many to count, and 2 pieces of dried macaroni. Drip pans underneath the flat top grill were more than half covered in a dried, dark brown substance with multicolored specks and debris from pinpoint to dime sized, too many to count. In an interview on 9/5/23 at 6:25 AM, Cook 2 indicated the shelves are normally cleaned at least once a week and as needed. She indicated the shelf should have been cleaned. She indicated she did not know how often the drip pans should be cleaned because she had never done it before. During a record review beginning 9/5/23 at 7:30 AM, Daily Freezer/Refrigerator Temperature Logs were reviewed. On the log labeled Back Cooler, temperatures were not filled out for September 2, 3 and 4. On the log labeled Back Freezer, temperatures were not filled out for September 2, 3 and 4. On the log labeled Walk-in Cooler, temperatures were not filled out for September 2, 3 and 4. On the log labeled Line Cooler, temperatures were not filled out for September 2, 3 and 4. On the log labeled Front Cooler, temperatures were not filled out for September 2, 3 and 4. On the log labeled Front Freezer, temperatures were not filled out for September 2, 3 and 4. During an interview on 9/5/23 at 6:25 AM, Cook 2 indicated refrigerator and freezer temperatures should be obtained and logged twice daily with any variances reported immediately to the Dietary Manager. In an interview on 9/5/23 at 6:42 AM, Registered			

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	Nurse 4 indicated all residents residing in the facility consumed food prepared in the kitchen. A current policy, undated, titled Shelves and Other Surfaces provided by the Administrator on 9/6/23 at 3:00 PM indicated splashes and spills should be wiped off as they occur. A current policy, undated, titled Daily Cleaning Schedule provided by the Administrator on 9/6/23 at 3:00 PM indicated the range catch pan should be cleaned daily. A current policy, dated 2/22/21, titled Safe Food Storage Guidelines provided by the Administrator on 9/6/23 at 3:00 PM indicated all products should be used by expiration date or discarded. During an interview, on 9/08/23 12:18 PM the administrator indicated the instructions at the top of the Daily Freezer/Refrigerator Temperature Log Received from Cook 2 on 9/5/23 at 7:30 AM served as the facility policy for temperature monitoring. The form indicated temperatures should be checked and recorded twice daily. 3.1-21(i)(3)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: Survey dates: September 5, 6, 7, and 8, 2023 Facility number: 001215	R 0000	=”” span=””> =”” span=””> =”” span=””> We respectfully request consideration for paper compliance. If you have any questions or concerns, please contact Amanda Duggan, HFA at 260-627-2191.	

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	Residential Census: 7 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed September 12, 2023		Thank you and have a great day! Amanda Duggan, HFA	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on record review and interview, the facility failed to ensure a resident's ability to self-administer medications through evaluation for 2 of 2 residents reviewed. (Residents 200 and Resident 201). Findings include: 1. Resident 200's record was reviewed on 9/6/23 at 10:35. Diagnosis included type 2 diabetes mellitus. Resident 200's record indicated he administered his own medications. His record did not contain an evaluation for his ability to self-administer his medications.	R 0216	Residents will be assessed to be able to self-administer medications per the regulations. This requirement was not met for 2 of 2 residents reviewed. All residents who self-administer medications have the potential to be affected by this deficient practice. DON and Nursing staff that work in the Assisted Living will be educated on this regulation and assessment. (Attachment H) All residents who self-administer medications will be reviewed and have an assessment completed and placed in their medical record.	09/28/2023

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	2. Resident 201's record was reviewed on 9/6/23 at 11:05. Diagnoses included type 2 diabetes mellitus, chronic obstructive pulmonary disease, atherosclerotic heart disease, uterine cancer, and breast cancer. Resident 201's record indicated she administered her own medications. Her record did not contain an evaluation for her ability to self-administer her medications. In an interview on 9/6/23 at 11:38 AM, QMA 3 indicated Resident 200 and Resident 201 were alert and oriented and their daughter set-up their medications weekly for them. QMA 3 indicated she had not seen a self-medication assessment form for the residents and there should be one. In an interview on 9/6/23 at 2:54 PM, RN 4 indicated he had reviewed Resident 200 and Resident 201 but had not assessed them for self-administration of medications. He indicated he completed a Medication Self-Administration Safety Screen on each resident on 9/6/23 and they passed the self-medication screening. In an interview on 9/7/23 at 12:52 PM, The Administrator indicated the facility did not have a policy for medication self-administration but provided the Medication Self-Administration Safety Screen tool. No policy was provided by survey exit.		Audits will be completed daily for two weeks, weekly for eight weeks and then monthly until 100% compliance is met for 6 months. Results will be reviewed daily and then monthly with the QAPI meetings. (Attachment B) ="" p=""> ="" p=""> ="" p=""> br=""> br=""> br=""> ="" p=""> ="" p=""> ="" p=""> ="" p=""	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling			

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	standards, including 410 IAC 7-24. Based on observation, interview, and record review the facility failed to ensure kitchen sanitation was maintained. 7 of 7 residents residing in the facility consumed food prepared in the facility kitchen. Findings include: During an observation on 9/5/23 at 6:00 AM a container of buttermilk was observed in the walk-in cooler. The container was about half full and a thick white substance was observed on top of a yellowish white liquid. The date stamped on the container was 8/15/23. A container labeled lemon pudding indicated the expiration date was 9/3/23. A container labeled cherry pie filling indicated the expiration date was 8/22/23. A container labeled marshmallow sauce indicated the expiration date was 9/1/23. A container labeled western dressing was dated 7/13/23-7/19/23. A container labeled ranch dressing did not have a date. A container stored with the other dressing bottles containing a white liquid did not have a label or date. An open package of salami was dated 8/16/23. 5 containers of salad were dated 9/1/23. In an interview on 9/5/23 at 6:22 AM, Cook 2 indicated leftover items should not be stored for more than 3 days. She indicated items should be used or discarded by the expiration date. A shelf underneath a counter in the kitchen area were 9 skillets. The shelf contained multiple brown and tan specks, too many to count, and 2 pieces of dried macaroni. Drip pans underneath the flat top grill were more than half covered in a dried, dark brown	R 0273	All residents have the right to have their food prepared and maintained with proper kitchen sanitation. This requirement was not met for 7 of 7 residents. All residents have the potential to be affected by this deficient practice. Dietary staff will be reeducated on label and dating items, food storage, equipment cleaning procedures, and logging refrigerator and freezer temperatures each shift. Administrator and or Designee will sign off on the daily kitchen audits for 30 days and then there after monthly. (Attachment G) Audits will be completed daily for two weeks, weekly for eight weeks and then monthly until 100% compliance is met for 6 months. Results will be reviewed daily and then monthly with the QAPI meetings. (Attachment B)	09/28/2023

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	substance with multicolored specks and debris from pinpoint to dime sized, too many to count. In an interview on 9/5/23 at 6:25 AM, Cook 2 indicated the shelves are normally cleaned at least once a week and as needed. She indicated the shelf should have been cleaned. She indicated she did not know how often the drip pans should be cleaned because she had never done it before. During an observation and interview on 9/5/23 at 12:04 PM, orange and red streaks and spots, too many to count were observed on the floor and shelving in the refrigerator in the assisted living dining room. Qualified Medication Aide (QMA) 3 indicated the refrigerator should have been cleaned. 7 containers of a red substance were observed in the drawer of the refrigerator with no label or date. QMA 3 indicated the items were salad dressing and should be labeled and dated. In the attached freezer, a large bowl filled with ice had an ice scoop lying in the ice supply with the handle touching the ice supply. QMA 3 indicated the ice scoop should not be stored touching the ice supply. During a record review beginning 9/5/23 at 7:30 AM, Daily Freezer/Refrigerator Temperature Logs were reviewed. On the log labeled Back Cooler, temperatures were not filled out for September 2, 3 and 4. On the log labeled Back Freezer, temperatures were not filled out for September 2, 3 and 4. On the log labeled Walk-in Cooler, temperatures were not filled out for September 2, 3 and 4. On the log labeled Line Cooler, temperatures were not filled out for September 2, 3 and 4. On the log labeled Front Cooler, temperatures were not filled out for September 2, 3 and 4. On the log labeled Front Freezer, temperatures were not filled out for September 2, 3			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155796	A. BUILDING 00 B. WING	09/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDARS THE	14409 SUNRISE CT LEO, IN 46765

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	and 4. During an interview on 9/5/23 at 6:25 AM, Cook 2 indicated refrigerator and freezer temperatures should be obtained and logged twice daily with any variances reported immediately to the Dietary Manager. In an interview on 9/5/23 at 6:42 AM, Registered Nurse 4 indicated all residents residing in the facility consumed food prepared in the kitchen. A current policy, undated, titled Shelves and Other Surfaces provided by the Administrator on 9/6/23 at 3:00 PM indicated splashes and spills should be wiped off as they occur. A current policy, undated, titled Daily Cleaning Schedule provided by the Administrator on 9/6/23 at 3:00 PM indicated the range catch pan should be cleaned daily. A current policy, dated 2/22/21, titled Safe Food Storage Guidelines provided by the Administrator on 9/6/23 at 3:00 PM indicated all products should be used by expiration date or discarded. During an interview, on 9/08/23 12:18 PM the administrator indicated the instructions at the top of the Daily Freezer/Refrigerator Temperature Log Received from Cook 2 on 9/5/23 at 7:30 AM served as the facility policy for temperature monitoring. The form indicated temperatures should be checked and recorded twice daily.			